550

Health

Budget function 550 includes federal spending for health care services, disease prevention, consumer and occupational safety, health-related research, and similar activities. The largest component of spending is the federal/state Medicaid program, which pays for health services for some low-income women, children, and elderly people as well as people with disabilities. Mandatory outlays for Medicaid increased by over 10 percent per year in the early 1990s and have risen significantly again in the past few years. CBO estimates that in 2001, the federal government will spend \$130 billion on Medicaid and a total of \$173 billion on function 550. Discretionary outlays make up only about \$34 billion of that total, but they have more than doubled since 1990. Those outlays have grown every year of the past decade.

Federal Spending, Fiscal Years 1990-2001 (In billions of dollars)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Estimate 2001
Budget Authority (Discretionary)	16.1	18.2	19.6	20.7	22.2	22.8	23.3	25.1	26.4	30.2	33.8	38.8
Outlays Discretionary Mandatory	14.9 <u>42.9</u>	16.2 <u>55.0</u>	18.0 <u>71.5</u>	19.6 79.8	20.5 86.6	22.0 93.4	22.6 96.8	23.0 100.9	24.9 106.6	26.9 114.1	30.0 124.5	33.8 139.2
Total	57.7	71.2	89.5	99.4	107.1	115.4	119.4	123.8	131.4	141.1	154.5	173.0
Memorandum: Annual Percentage Change in Discretionary Outlays		8.8	11.1	9.3	4.6	7.2	2.5	1.7	8.2	8.4	11.4	12.5

550-01 Reduce Funding for the National Health Service Corps

Savings				
(Millions of dollars)				
Budget				
Authority Outlays				

Relative to Current Appropriations				
2002	32	10		
2003	32	24		
2004	32	29		
2005	32	32		
2006	32	32		
2002-2006	160	127		
2002-2011	320	287		
Relative to Inflated Appropriations				
2002	25	1.1		

	_	
2002	35	11
2003	38	27
2004	41	35
2005	43	40
2006	46	43
2002-2006	203	156
2002-2011	478	411

SPENDING CATEGORY:

Discretionary

The National Health Service Corps (NHSC), which is administered by the Health Resources and Services Administration, attempts to increase access to primary care services for people who live in designated Health Professional Shortage Areas. The Corps provides scholarships or loan repayment for health professionals in exchange for the recipients' agreeing to serve in a shortage area for a specified period. In recent years, over 2,500 health professionals have been serving with the NHSC—most of them work in underserved rural areas, but about 40 percent are in urban areas. More than half of the participants are doctors, but a substantial fraction of Corps practitioners are dentists, nurse-practitioners, or physician assistants.

This option would reduce budget authority for the NHSC by 25 percent and freeze it at the new level. Over the period from 2002 to 2011, this option would save \$287 million in outlays relative to current appropriations and \$411 million relative to current appropriations adjusted for inflation. This option would result in a program whose funding level in 2011 was roughly half of the 2001 level adjusted for inflation.

Although some people living in underserved areas receive greater access to health services because of the Corps, critics of the program may question whether it distributes health professionals efficiently. Concerns center on whether the services that an NHSC professional provides in an underserved area outweigh the value of the services that he or she would have provided in some other location by enough to justify the public expense of a scholarship or loan repayment. Moreover, some NHSC participants may displace other health professionals. For example, certain of the more desirable shortage areas might have been able to attract health professionals if a number of the potential patients were not already being served by Corps professionals. In addition, some observers might question whether NHSC funding represents a good return on investment. Although retention rates have increased substantially, almost half of the recruits do not remain in their underserved location beyond their obligation.

Reducing funding for the NHSC would lessen access in some underserved areas to the services provided by health professionals, although the Corps might be able to mitigate the effects of budget cuts by spending more of its resources on relatively inexpensive nonphysician providers. But even if the Corps refocused its remaining funds on nonphysician practitioners, the services of those professionals would not fully substitute for the skills and services offered by physicians. In the event of a cut in funding, community health centers, which obtain about a quarter of their physicians from the NHSC, would probably reduce their services. Moreover, lower levels of funding would probably have a disproportionate impact on people from minority groups, who constitute the majority of patients served by Corps professionals.

Reduce the Floor on the Federal Matching Rate in Medicaid

	Outlay Savings (Millions of dollars)
2002	4,060
2003	4,430
2004	4,850
2005	5,300
2006	5,800
2002-2006	24,440
2002-2011	62,630

SPENDING CATEGORY:

Mandatory

RELATED OPTION:

550-03

The Medicaid program pays for medical assistance for certain low-income families, for low-income people who receive Supplemental Security Income, and for other low-income individuals—mostly children and pregnant women. The federal government and the states pay for the program jointly, with the federal government's share generally varying according to a formula that depends on a state's per capita income. High-income states pay for a larger share of benefits than do low-income states, but by law, the federal share can be no less than 50 percent and no more than 83 percent. In 2002, the 50 percent floor will apply to 11 states: Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, and New York.

Under this option, the 50 percent floor would be reduced to 45 percent, generating savings of about \$4.1 billion in 2002 and \$62.6 billion through 2011. (The option assumes that matching rates for other programs that are jointly funded by the federal and state governments would be unaffected, even though some programs have matching rates that are tied to the rate for Medicaid. Savings would be greater if matching rates in those programs also declined.)

Proponents of this change argue that the allocation formula does not adequately address differences in the tax bases of the states and that high-income states should bear a larger share of the cost of their programs. If the floor was reduced to 45 percent, federal contributions would be more closely related to the state's per capita income, and five of the 11 jurisdictions would still be paying less than the formula alone would require.

Opponents of reducing the 50 percent floor believe that higher incomes in the affected states partly reflect higher costs of living. If the option was adopted, those states would have to compensate for the lower matching rates by reducing Medicaid benefits, reducing expenditures for other services, or raising taxes.

550-03 Reduce the Enhanced Federal Matching Rates for Certain Administrative Functions in Medicaid

	Outlay Savings (Millions of dollars)
2002	000
2002	880
2003	1,110
2004	1,200
2005	1,290
2006	1,400
2002-2006	5,880
2002-2011	14,860

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

550-02, 550-04-A, and 550-04-B

Under current law, the federal government pays part of the costs that states incur in administering their Medicaid programs. For most administrative activities, the federal matching rate is 50 percent, but that rate is higher for certain activities. For example, the federal government pays 75 percent of the costs of skilled medical professionals who are employed in Medicaid administration, 75 percent of the costs of utilization review, 90 percent of the development costs of systems for claims processing and information management, and 75 percent of the costs of operating such systems.

The purpose of enhanced matching rates is to give states incentives to develop and support particular administrative activities that the federal government considers important for the Medicaid program. But once the administrative systems are operational, there may be less reason to continue to pay higher rates. If the federal share of all Medicaid administrative costs was 50 percent, savings would be \$880 million in 2002 and \$14.9 billion over the 2002-2011 period.

Without the higher matching rates, states might be inclined to cut back on some activities, with adverse consequences for the quality of care and for program management. States might, for example, hire fewer nurses to conduct utilization review and oversee care in nursing homes, or they might undertake fewer improvements to their management information systems. However, if the Congress wished to protect particular administrative functions, it could maintain the higher matching rates for them while it reduced the matching rates for others.

550-04-A Restrict the Allocation of Common Administrative Costs to Medicaid

	Outlay Savings (Millions of dollars)
2002	290
2003	330
2004	390
2005	390
2006	390
2002-2006	1,790
2002-2011	3,740

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

550-03 and 550-04-B

Public assistance programs have certain administrative requirements that are common to the enrollment process, such as the collection of information on a family's income, assets, and demographic characteristics. Before the 1996 welfare reform law, the three major public assistance programs—Aid to Families with Dependent Children (AFDC), Food Stamps, and Medicaid—all reimbursed states for 50 percent of most of their administrative costs. But states usually charged the common administrative costs of those programs to AFDC.

The welfare reform law replaced AFDC and some related programs with the Temporary Assistance for Needy Families (TANF) block-grant program. The block grants that states receive are based on historical federal welfare expenditures, including administrative costs. Thus, insofar as states had previously paid for the common administrative costs of public assistance programs out of AFDC funds, those amounts are now included in their block grants. Although the welfare reform act is silent about the cost allocation process, the Department of Health and Human Services requires states to charge part of the common administrative costs of Medicaid and TANF to Medicaid, even if those costs are already included in the states' TANF block grants.

This option would reduce federal reimbursement for Medicaid administrative costs to reflect the share of those costs that are assumed to be covered by the TANF block grant; it would also prohibit states from using TANF funds to pay for those costs. The amount of the reduction would be about one-third of the common costs of administering the Medicaid, AFDC, and Food Stamp programs that were charged to AFDC during the base period used for determining the amount of the TANF block grant. (A similar adjustment has already been made in the amount the federal government pays the states for the administrative costs of the Food Stamp program.) Savings would be \$290 million in 2002 and \$3.7 billion over the 2002-2011 period. If the policy permitted the states to use TANF funds to pay for those costs, savings would be \$100 million in 2002 and \$3.6 billion over the 2002-2011 period.

The reductions in federal reimbursements, however, would come at a time when states were attempting to expand their outreach activities to enroll more eligible children in Medicaid and the State Children's Health Insurance Program. Reducing those payments might result in fewer eligible people being enrolled in Medicaid.

550-04-B Reduce Spending for Medicaid Administration

	Outlay Savings (Millions of dollars)
2002	2,250
2003	2,670
2004	3,010
2005	3,400
2006	3,820
2002-2006	15,150
2002-2011	42,280

SPENDING CATEGORY:

Mandatory

RELATED OPTIONS:

550-03 and 550-04-A

An alternative strategy to limit federal payments for Medicaid's common administrative costs would base those payments to the states on matching payments for administrative costs in the period before the Temporary Assistance for Needy Families (TANF) block-grant program was established. Under this option, the federal government would cap the amount per enrollee that it paid the states for Medicaid administration. The per capita limit would grow at 5 percent a year from the base-year amount, which would be the administrative costs per enrollee for which the states claimed matching payments in 1996. Savings would be \$2.3 billion in 2002 and \$42.3 billion over the 2002-2011 period.

Using this approach, states that before TANF's implementation allocated Medicaid's common administrative costs to the Aid to Families with Dependent Children program would not have those costs included in their projected Medicaid administrative costs. But states that claimed those costs through the Medicaid program would have them built into their Medicaid administrative cost base. The option would generate large savings because the actual average rate of growth of administrative costs was more than 5 percent a year in the 1996-2000 period and is also projected to exceed 5 percent in 2001 and later years.

550-05 Convert Medicaid and Medicare DSH Payments into a Block Grant

	Outlay Savings (Millions of dollars)
2002	1,320
2003	1,230
2004	1,440
2005	1,670
2006	2,040
2002-2006	7,700
2002-2011	23,400

SPENDING CATEGORY:

Mandatory

Under current law, states are required to adjust Medicaid payments to hospitals that treat large numbers of low-income and Medicaid patients, which are known as disproportionate share (DSH) hospitals. During the past decade, states used creative financing mechanisms to generate large federal matching payments through the DSH program, and federal DSH costs soared. The Congress enacted a series of restrictions on DSH payments, culminating in those in the Balanced Budget Act of 1997 (BBA). Federal outlays for Medicaid DSH payments were \$8.4 billion in 2000 and are projected to rise to \$9.1 billion by 2006.

In addition to Medicaid DSH payments, hospitals that serve a disproportionately large share of low-income patients may also receive higher payment rates under Medicare's prospective payment system. Implemented in 1986, the Medicare disproportionate share adjustment was intended to account for the presumably higher costs of treating Medicare patients in such hospitals. Recently, however, the adjustment has been seen more as a means to protect access to care for Medicare and low-income populations by providing financial support to hospitals serving large numbers of low-income patients. Outlays for Medicare DSH payments rose rapidly between 1989 and 1997, reaching \$4.5 billion in 1997. Reductions have been made in DSH payments since the BBA; as a result, payments in 2002 will be \$5.1 billion.

An alternative approach to providing federal financial support for health care institutions that serve the poor and uninsured would be to convert the current Medicaid and Medicare disproportionate share programs into block grants to the states. The grants could be constrained to grow more slowly than DSH payments would have grown under current law. In exchange for slower growth, states could be given flexibility to use the funds to meet the needs of their low-income uninsured populations in the most cost-effective ways.

Under this illustrative option, which assumes a maintenance-of-effort requirement for states, the aggregate block grant in 2002 would be the sum of Medicare DSH payments and Medicaid DSH allotments for 2001, reduced by 10 percent. In subsequent years, the block grant would be indexed to the increase in the consumer price index for urban consumers less 1 percentage point. Additional savings would accrue to Medicare because lower DSH payments would reduce payment updates to plans participating in Medicare+Choice. Total savings would be \$1.3 billion in 2002 and \$23.4 billion for the 2002-2011 period.

Giving the states more discretion in allocating DSH payments could result in those funds being targeted more appropriately and equitably to facilities and providers that serve low-income populations. But allowing the states to allocate the payments could cause some large urban hospitals to receive less public funding than they do now. Under the current system, the extent to which DSH payments translate into services for low-income patients is uncertain. A recent study suggests that state and local governments reduce their subsidies to disproportionate share hospitals by an amount equal to federal DSH payments.

550-06 Change Medicaid's Formula for Rebates on Prescription Drugs

	Outlay Savings (Millions of dollars)
2002	400
2003	380
2004	360
2005	390
2006	440
2002-2006	1,970
2002-2011	5,060

SPENDING CATEGORY:

Mandatory

Medicaid's expenditures for prescription drugs have increased rapidly in recent years, reaching \$20 billion in 2000. State Medicaid agencies pay pharmacies amounts that are based on each drug's posted average wholesale price (AWP), which is a list price published by the manufacturer. Medicaid recoups about 20 percent of those expenditures through rebates paid by drug manufacturers. The amount of the rebate is based in part on the average manufacturer's price (AMP) of the drug, which is the average price the manufacturer actually receives for drugs distributed to retail pharmacies. Manufacturers of brand-name drugs generally must rebate the larger of a fixed percentage of the AMP or the difference between the AMP and the best price at which they sell the product. Makers of generic drugs must pay a fixed percentage of the AMP.

Because Medicaid payments to pharmacies depend on prices published by manufacturers, increases in those prices directly raise expenditures without increasing rebate amounts. Manufacturers of generic drugs, who must compete for pharmacies' business, have an incentive to sell to pharmacies at a low price but to publish a high AWP. Manufacturers of brand-name drugs also suffer no penalties for raising average wholesale prices. To counteract the effects of higher list prices and decrease Medicaid costs, this option would substitute the average wholesale price for the average manufacturer's price in calculating the fixed-percentage formulas. This option would also eliminate the best-price rebates for brand-name drugs and reduce the fixed-percentage rebate for generic manufacturers from 11 percent to 5 percent.

The Congressional Budget Office estimates that the net effect of those changes would be to reduce mandatory federal spending by \$400 million in 2002 and by \$5 billion over the 2002-2011 period. Effects on the cost of pharmacy benefits paid for by discretionary programs would be small.

The main advantage of this option is that Medicaid costs would be reduced. A secondary advantage is that manufacturers would pay a higher rebate whenever they raised average wholesale prices. That extra payment might discourage manufacturers from raising list prices as much as they might otherwise. Eliminating the best-price rebates would probably lead to higher rebates for private-sector health maintenance organizations and managed pharmacy plans. However, manufacturers might charge higher prices to pharmacies in attempts to recoup their costs. As pharmacies experienced those higher costs of acquiring drugs, they would raise prices to private customers. All of those effects could change the cost of medical benefits paid by employers. The net direction of the effect on federal revenues is uncertain.

Pharmacies might also pressure state Medicaid agencies for higher reimbursement rates. To the extent that they were successful in receiving higher reimbursements from the states, the savings in Medicaid outlays would diminish over time. CBO's estimate takes into account that possibility. If unsuccessful, some pharmacies might refuse to participate in Medicaid or might close outlets with high concentrations of Medicaid beneficiaries.

550-07 Reduce Subsidies for Health Professions Education

Savings				
(Millions of dollars)				
Budget				
Authority Outlays				

Appropriations				
2002	244	75		
2003	244	180		
2004	244	220		
2005	244	240		
2006	244	240		
2002-2006	1,220	950		
2002-2011	2,440	2,145		

Relative to Current

Relative to Inflated Appropriations

2002	250	75
2003	255	185
2004	260	230
2005	265	255
2006	270	260
2002-2006	1,300	1,005
2002-2011	2,730	2,380

SPENDING CATEGORY:

Discretionary

The Congress provided \$244 million to the Public Health Service in 2001 to fund subsidies to institutions for educating physicians, nurses, and public health professionals. Those funds primarily furnish support through grants and contracts to schools and hospitals for designated training programs in the health professions. The programs promote primary care and community-based training for physicians and other health professionals as well as nursing education:

- o *Primary care and community-based training*. Several programs provide federal grants to medical schools, teaching hospitals, and other training centers to develop, expand, or improve graduate medical education in primary care specialties and other allied health fields and to encourage practice in rural and low-income urban areas. Funding for 2001 is \$167 million.
- O Nursing education. The subsidies to nursing schools are meant to promote nursing education, including graduate training for nurse administrators, educators, and nursing specialists such as nurse-midwives and nurse-practitioners. Funding for 2001 is \$77 million.

Over the period of 2002 to 2011, eliminating those grants and subsidies would save \$2.1 billion in outlays relative to current appropriations and \$2.4 billion relative to current appropriations adjusted for inflation.

The principal justification for this option is that market forces provide strong incentives for people to seek training and jobs in the health professions. Over the past several decades, the number of physicians—the principal health profession targeted by the subsidies—has rapidly increased, rising from 142 physicians in all fields for every 100,000 people in 1960 to 285 in 1999. In the case of nurses, if a shortage existed, higher wages and better working conditions would attract more people to the profession and more trained nurses to nursing jobs, and would encourage more of them to seek advanced training.

The major disadvantage of eliminating the subsidies is that the incentives supplied by market forces may not be strong enough to entirely achieve the desired manpower levels. For example, third-party reimbursement rates for primary care may not encourage enough physicians to enter those specialties and may not include sufficient financial inducements to increase access to care in rural and inner-city areas. In addition, fewer people might choose advanced training in nursing, which could limit the opportunities to use relatively inexpensive physician substitutes.

550-08 Combine and Reduce Public Health Service Grants

Savings		
(Millions of dollars)		
Budget		
Authority Outlays		

Appropriations			
2002	520	170	
2003	520	435	
2004	520	485	
2005	520	505	
2006	520	510	
2002-2006	2,600	2,110	
2002-2011	5,200	4,670	

Relative to Current

Relative to Inflated Appropriations

2002	640	210
2003	750	570
2004	855	725
2005	965	855
2006	1,080	965
2002-2006	4,290	3,325
2002-2011	11,445	9,875

SPENDING CATEGORY:

Discretionary

In its appropriations for 2001, the Congress provided about \$5.2 billion for nine grant programs administered by the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Four of the nine programs—the Maternal and Child Health Care Block Grant, HIV Care Grants to States, the Family Planning Block Grant, and the Healthy Start Initiative—are administered by HRSA. Those grants support programs that provide child health services, including immunizations, well-child examinations, and services for children with special health care needs; medical care and social support services for people who have been diagnosed with the human immunodeficiency virus; family planning services; and efforts to reduce infant mortality. CDC administers the Preventive Health and Health Services Block Grant, which is distributed to the states for programs that support Healthy People 2010, the nation's objectives for promoting health and preventing disease.

The remaining four grants—the Substance Abuse Performance Partnership Block Grant, the Mental Health Performance Partnership Block Grant, the Projects for Assistance in Transition from Homelessness (PATH) program, and the Protection and Advocacy Program—are administered by SAMHSA. The grants support substance abuse prevention programs, community-based mental health services for adults with serious mental illnesses and children with severe emotional disturbances, services for people with mental illness or substance abuse disorders who are also either homeless or at risk of becoming homeless, and programs that investigate allegations of abuse and neglect in facilities that provide care for people with mental illness.

This option would combine these funds into two large grants and reduce budget authority to 90 percent of the 2001 level. The grants currently administered by HRSA and CDC would be combined and administered by HRSA, and the grants currently administered by SAMHSA would be combined and administered by that agency. Over the period from 2002 to 2011, this option would save about \$4.7 billion in outlays relative to current appropriations and \$9.9 billion relative to current appropriations adjusted for inflation. This option would result in a program whose funding level in 2011 was 26 percent of the 2001 level adjusted for inflation.

The principal justification for this option is that each state also would be given added flexibility to direct the grant funds toward programs that the state considers likely to have the most favorable impact. Conditions vary substantially by state, yet grant requirements often compel states to devote resources to programs that may or may not meet a given state's needs. By reducing funds for lower-priority programs, states could allocate additional resources to programs that they considered more important.

The option's major disadvantage is that improved flexibility might not entirely make up for the 10 percent cut in federal funds for state programs. The states would have to make difficult decisions to trim programs that benefited vulnerable population groups. Alternatively, if reducing resources was not feasible, they might have to raise state taxes or cut other state programs.

550-09 Adopt a Voucher Plan for the Federal Employees Health Benefits Program

	Savings ^a	
	(Millions	of dollars)
	Discre-	Manda-
	tionary ^b	tory
2002	300	200
2003	600	500
2004	1,000	800
2005	1,400	1,100
2006	1,800	1,400
2002-2006	5,100	4,000
2002-2011	21,500	17,400

- a. Estimates do not include any savings realized by the U.S. Postal Service.
- Savings measured from the 2001 funding level adjusted for premium increases and changes in employment.

SPENDING CATEGORIES:

Discretionary and mandatory

RELATED OPTION:

550-10

RELATED CBO PUBLICATION:

Comparing Federal Employee Benefits with Those in the Private Sector (Memorandum), August 1998. The Federal Employees Health Benefits (FEHB) program provides health insurance coverage for over 4 million active federal employees and annuitants, as well as for their 4.6 million dependents and survivors, at a cost to the government of almost \$15 billion in 2001. The cost-sharing structure of the FEHB program encourages federal employees to switch from high-cost to lower-cost plans to blunt the effects of rising premiums; cost sharing also intensifies competitive pressures on all participating plans to hold down premiums. The Balanced Budget Act of 1997 set the federal government's share of premiums for employees and annuitants (including family coverage) at 72 percent of the average weighted premium of all plans beginning January 1, 1999. (The employer's costs are higher under the U.S. Postal Service's collective bargaining agreement.) The act still requires policyholders to pay at least 25 percent of the premium of any particular plan. (Since October 1, 2000, employees' premiums have come out of pretax income, a benefit long enjoyed by employees in the private sector.)

To reduce expenditures, the government could offer a flat voucher for health insurance premiums. It could pay the first \$2,400 of premiums for employees and retirees (\$5,500 for family coverage). Those amounts are based on the government's average expected contribution for nonpostal employees in 2001 and would increase annually by the rate of inflation rather than by the average weighted rate of change for premiums in the FEHB program. Budgetary savings would come from indexing the premiums to inflation rather than to the growth of premiums, which the Congressional Budget Office expects will rise at a rate more than twice that of inflation. Savings in discretionary spending from lower payments for current employees and their dependents would begin to accrue after the first year of implementation and would total \$5.1 billion over five years and \$21.5 billion over 10 years. Savings in mandatory spending from reduced payments for retirees would be \$4.0 billion over five years and \$17.4 billion over 10 years.

This option would strengthen price competition among health plans in the FEHB program because almost all current enrollees would be faced with paying all of the incremental premiums above the voucher amount. In addition, removing the requirement that enrollees pay at least 25 percent of the premiums should increase price competition among low-cost plans to attract participants. In the lowest-cost plans, the government would pay almost the entire premium.

On the downside, participants would pay an ever-increasing share of their premiums—possibly over 40 percent by 2006—if premiums rose as expected. The added cost to enrollees could exceed \$800 per worker in 2006 and more in later years. Currently, large private-sector plans provide better health benefits for their employees—although not for their retirees—which might make it harder for the government to attract and retain high-quality workers. (Recent increases in the FEHB program's coverage for mental health and substance abuse services might narrow the differences with private-sector plans.) In addition, for current retirees and long-time federal workers, the option would cut benefits that have already been earned. Finally, the option could strengthen existing incentives for plans to structure benefits to disproportionately attract people with lower than average health care costs. That "adverse selection" could destabilize other plans.

550-10 Base Retirees' Health Benefits on Length of Service

	Savir (Millions of Budget Authority	of dollars)
2002	60	60
2003	120	120
2004	190	190
2005	250	250
2006	330	330
2002-2006	950	950
2002-2011	4,050	4,050

Estimates do not include any savings realized by the U.S. Postal Service.

SPENDING CATEGORY:

Mandatory

RELATED OPTION:

550-09

RELATED CBO PUBLICATION:

Comparing Federal Employee Benefits with Those in the Private Sector (Memorandum), August 1998. Federal retirees are generally eligible to continue receiving benefits from the Federal Employees Health Benefits (FEHB) program if they have been participants during their last five years of service and are eligible to receive an immediate annuity. About 80 percent of eligible new retirees elect to receive health benefits. After age 65, the FEHB program's benefits are coordinated with those of Medicare; the program pays amounts not covered by Medicare (but no more than the amounts it would have paid in the absence of Medicare). Participants and the government share the cost of premiums. The government's share for annuitants and employees is 72 percent of the weighted average premium of all participating plans (up to a cap of 75 percent of the total premium). In 2001, the government expects to pay \$5.6 billion in premiums for 1.9 million annuitants and their dependents and survivors.

Under this option, federal retirees' health benefits would be reduced for those with relatively short federal careers while the right of retirees to participate in the FEHB program would be preserved. For new retirees only, the government's share of the premium could be cut by 2 percentage points for every year of service under 30. For example, the government's contribution would fall to 52 percent of the average premium for a retiree with 20 years of service. In 2000, about 55 percent of the roughly 73,000 new retirees who continued in the FEHB program had less than 30 years of service. The average new retiree affected by the proposal would pay 40 percent of the premium rather than 28 percent, an annual increase of \$900 in 2002. The estimated savings to the government in mandatory spending would total \$60 million in 2002 and \$950 million over five years. Ten-year savings would rise to \$4.1 billion. (The estimates exclude savings realized by the Postal Service because, while its retirees participate in the FEHB program, reductions in its operating costs eventually benefit only mail users.)

The option might make the government's compensation mix fairer and more efficient by improving the link between service and deferred compensation. The option would also help bring federal benefits closer to those available from private firms. Federal retirees' health benefits are significantly more generous than those offered by most large private firms, which have been aggressively paring and, in some cases, eliminating retirees' health benefits in recent years. A survey of all U.S. employers found that fewer than half provide medical benefits to retirees. Moreover, of those companies still offering such benefits, some are no longer promising open-ended health benefits for retirees but are instead promising to make fixed dollar contributions to insurance coverage.

A negative aspect of the option is that it would mean a substantial cut in benefits whose effects would be felt most strongly by the roughly 20 percent of new retirees with less than 20 years of service. The option could also encourage some employees with short service careers to delay retirement, whereas others might accelerate retirement plans to avoid the new rules.

550-11 Establish User Fees for New Medical Devices Regulated by the FDA

Savings		
(Millions of dollars)		
Budget		
Authority Outlays		

Relative to Current Appropriations		
2002	28	28
2003	48	48
2004	41	41
2005	42	42
2006	44	44
2002-2006	203	203
2002-2011	448	448
Relative to Inflated Appropriations		

2002	28	28
2003	48	48
2004	41	41
2005	42	42
2006	44	44
2002-2006	203	203
2002-2011	448	448

SPENDING CATEGORY:

Discretionary

The Prescription Drug User Fee Act of 1992 (PDUFA) authorized the Food and Drug Administration (FDA) to collect fees from pharmaceutical manufacturers to help speed up the review of applications for the marketing and approval of new drugs. The Food and Drug Administration Modernization Act of 1997 reauthorized the PDUFA program but did not address user fees for medical devices. The Congress considered but did not pass legislation authorizing user fees for medical devices in 1994. The Clinton Administration's 2001 budget included a proposal to impose user fees on medical devices as well as on other products regulated by the FDA.

Manufacturers must notify the FDA before they market any new medical device, and for certain products, they must obtain approval before marketing them. Establishing fees of \$7,000 for each new medical device requiring premarket notification, \$3,500 for those devices qualifying for abbreviated or special notification processes, \$60,000 for each new medical device needing premarket approval, and \$7,000 for each application for a supplemental premarket approval would raise \$28 million in 2002 and \$448 million during the 2002-2011 period. Taken together, those fees would ultimately constitute about 30 percent of the cost of regulating medical devices. The estimates assume that only a few exemptions would be granted for small businesses or devices with very small markets.

Establishing user fees for new medical devices would require new authorizing legislation. To generate budgetary savings, that legislation would have to permit user fee collections to offset other FDA appropriations for salaries and expenses. PDUFA does not permit that offset for prescription drug user fees.

Proponents of user fees for medical devices argue that regulatory activities benefit consumers as well as industry. The FDA's primary function is to ensure public safety by monitoring the quality of pharmaceutical products, medical devices, and food. Firms benefit from the public confidence that results from the FDA's regulation, those proponents maintain, and should therefore bear a share of the costs of those activities.

People who oppose levying user fees on new medical devices might argue that the agency's current oversight of medical devices is excessive and unnecessary. Rather than adding user fees, those opponents might contend that the FDA could cut costs by scaling back its regulatory requirements.